U.S. Department of Labor

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MAILED: 3/8/2001

IN THE MATTER OF:	
Debra Webb-McFadden Claimant	
v.	
Patent Pending Restaurant Employer	
and	Case No.: 2000-DCW-0013
	OWCP No.: 40-153714
Zurich American Insurance Carrier	
and	
Director, Office of Workers' Compensation Programs, United States Department of Labor Party-in-Interest	

APPEARANCES:

Michael V. Kowalski, Esq.
For the Claimant

David O. Godwin, Jr., Esq.
For the Employer/Carrier

BEFORE: **DAVID W. DI NARDI**
Administrative Law Judge

DECISION AND ORDER - AWARDING MEDICAL BENEFITS

This is a claim for worker's compensation benefits under the Longshore and Harbor Workers' Compensation Act, as amended (33

U.S.C. §901, **et seq.**), as extended by the provisions of the District of Columbia Workers' Compensation Act, 36 D.C. Code 501, **et seq.**, herein referred to as the "Act." The hearing was held on December 7, 2000 in Washington, D.C., at which time all parties were given the opportunity to present evidence and oral arguments. The following references will be used: TR for the official hearing transcript, ALJ EX for an exhibit offered by this Administrative Law Judge, CX for a Claimant's exhibit and RX for an Employer's exhibit. This decision is being rendered after having given full consideration to the entire record.

Post-hearing evidence has been admitted as:

Exhibit No.	**Item**	**Filing Date**
RX 3	Attorney Godwin's letter filing the	01/22/01
RX 4	January 11, 2001 supplemental report of Dr. Neil Kahanovitz	01/22/01
RX 5	Employer's post-hearing memorandum	01/22/01
CX 11	Attorney Kowalski's memorandum in support of Claimant's claim for benefits, as well as the	01/29/01
CX 12	December 6, 2000 report of Dr. Hampton J. Jackson, Jr.	01/29/01
CX 13	November 27, 2000 report of Dr. Jackson	01/29/01
CX 14	December 6, 1996 Operative Report of Dr. Jackson	01/29/01

The record was closed on January 29, 2001 as no further documents were filed.

PROCEDURAL HISTORY

Debra Webb ("Claimant" herein) was injured in the course of her employment with the Employer, a company subject to the jurisdiction of the Act, and Claimant has settled her entitlement to further indemnity benefits. However, her entitlement to future medical benefits was left open and this has given rise to the present proceeding. (TR 10-13)

The unresolved issue in this case is Claimant's entitlement to the surgical treatment recommended by her treating physician.

Debra Webb-McFadden ("Claimant" herein), forty (40) years of age, with a high school education, as well as one year of classes at George Washington University, and a varied employment history, was injured on May 22, 1980 in the course of her employment with the Employer joined herein. Claimant was initially treated by Dr. Earl C. Mills and then by Dr. Hampton Jackson, and their records relating to their treatment of Claimant are in evidence as CX 1, CX 8 and CX 10, and these will be briefly summarized herein.

Noteworthy is the January 29, 1981 report of July 26, 1980 wherein Dr. Allen Brimmer states as follows (CX 9):

"TO WHOM IT MAY CONCERN:

This is a letter in support of Debra's disability claim. Ms. Webb has been followed here since 7/9/80 for back pain after falling at work and injuring her back. X-rays are normal. The patient was last seen 8/19/80, and at that time was still having considerable pain, although she was going to physical therapy and resting at home. Physical examination shows considerable muscle spasm on the right side which was tender to palpation and extended to the level of the 5th thoracic vertebrae. There was marked limitation of motion of the back due to pain.

Ms. Webb was started on a new muscle relaxant and continued on an anti-inflammatory and physical therapy.

DIAGNOSIS: Low back pain of 10 weeks duration due to muscle spasm after fall at work

PROGNOSIS: Good, but prolonged course so far suggests

patient may have further problems intermittently.

DISABILITY: Now complete. While it is difficult to estimate duration, I would estimate 1 month more," according to the doctor.

As of January 29, 1981 Dr. Brimmer stated as follows (**Id.**):

"This is the updated report on Debra Webb which you requested.

She fell at work 5/22, injuring her back and had been treated with muscle relaxants, anti-inflammatory medication and physical therapy which were only partially effective in relieving her pain. X-rays done were normal.

I first saw her 8/19/80 when she still complained of considerable pain on her right side preventing her from carrying on her usual activities. She has marked muscle spasm over much of her right back. She reported that the injury occurred in June, so my diagnosis was lumbar sprain with muscle spasm of 10 weeks duration. I put her on a combination of muscle relaxant + anti-inflammatory + continued the physical therapy.

She was next seen 10/20/80 and then reported that she was better, though the physical therapy seemed to be making the pain worse, though massage helped. She reported that she was able to walk two blocks if she did it slowly. She was still tender over the entire paraspinal area, though the pain was less. It was noted she was in high heels and instructed to wear low heels for the back. Also noted was a bladder infection which was treated. Because the anti-inflammatory was helping, she was continued on it an instructed to begin walking and swimming up to tolerance.

She was next seen 1/5/81 at which time she felt that both the muscle relaxant and anti-inflammatory helped the pain and that she was doing physical therapy at home. Examination of the back showed only muscle spasm, this time limited to the lower thoracic area. I felt that she was ready to return to a trial period of work under the following limitations: 1. No lifting

2. No prolonged sitting or standing

Her period of total disability extends 5/22/80 - 1/5/81. She is still on partial disability which began either 1/6/81 or 1/12. (My records to not specify.),” according to the doctor.

Claimant’s lumbar symptoms persisted and, as conservative treatment did not alleviate the symptoms, she was referred to Dr. Earl C. Mills and the doctor states as follows in his May 4, 1981 Discharge Summary report (CX 6):

“DISCHARGE SUMMARY

“CHIEF COMPLAINT: Low back pain, bilateral lower extremity pain.

“HISTORY OF PRESENT ILLNESS: The patient is a 20-year-old female with chronic low back and bilateral lower extremity pain allegedly following a work-related injury. She was recently admitted to Providence Hospital and underwent lumbar myelogram and subsequently lumbar discogram, the latter showing evidence of disc degeneration at the L4-5 level. She was admitted this time for a lumbar laminectomy.

General physical examination was unremarkable. Neurological examination was consistent with low back pain syndrome most likely related to the degenerative disc as documented on discography.

“HOSPITAL COURSE AND TREATMENT: She was taken to the operating room on 4-29-81 and underwent a lumbar laminectomy at L4, partial hemilaminectomy of L5 bilaterally and excision of degenerative L4 disc and total foraminotomy for the L5 root performed. Postoperative course was uneventful. She was subsequently discharged on 5-4-81 to be seen in the office in approximately three weeks.

“FINAL DIAGNOSIS: Degenerated lumbar disc, L4-5 bilaterally.

“OPERATIVE PROCEDURE: Lumbar laminectomy.”

Claimant was then referred to the George Washington University Medical Center for a neurological consultation and Dr. S. Koulouris states as follows in her June 18, 1982 report (CX 7):

“HISTORY OF THE PRESENT ILLNESS: This 21 year old lady allegedly sustained a work related injury on 22 May 1980.

Subsequently she has been under the care of Dr. Earl Mills, and in the course of her treatment she underwent a myelogram which was normal and a lumbar discogram which apparently showed evidence of discogenic disease at the L4-L5 level. She underwent a lumbar laminectomy in April 1981. The patient claims that she has not had any significant relief after her operation. She has been under different modes of treatment including physical therapy, epidural blocks and transcutaneous nerve stimulators. She has been taking a number of medications and presently she is taking Valium sparingly, and Tylenol for pain.

"EXAMINATION: Examination shows the patient to be a pleasant but apprehensive lady, very thin in no apparent distress. Examination of the central nervous system and the cranial nerves is within normal limits. Cervical and thoracic spine are normal. Examination of the lumbar spine shows a well healed lumbar laminectomy incision with a minimal amount of paravertebral muscle spasm present. The patient is unable to bend backwards and forwards and I believe this is guarding an apprehensive more than real disability. There is no tenderness on palpation of the spinous processes or the sciatic notches. The straight leg raising test is negative, bilaterally, however, any attempt to raise or manipulate her leg causes complaints on the part of the patient because of anterior thigh pain. The PATRICK's maneuver was also unremarkable although again any attempt to move it was causing significant guarding on the part of the patient. Reflexes are 2+ and symmetrical and there is no motor or sensory change in the lower extremities. The peripheral pulses are normal. She denies any sphincter disturbances. The remaining of the neurological examination is unremarkable.

"IMPRESSION AND RECOMMENDATIONS: Status post operative after lumbar laminectomy L4-L5, 14 months ago. I do not see any evidence of discogenic problem or any clinical evidence of radiculopathy at this point. Her symptoms could be related to scar tissue from surgery and I certainly feel that any reasonable effort should be made to release this patient back to work. A CT scan of the lumbar spine is recommended at this time in order to further evaluate her post-operative status. If she fails to respond favorably to these measures then consideration could be given for her to be enrolled in one of the chronic pain treatment programs, either in John Hopkins University Hospital or elsewhere. Certainly she does not seem to be a candidate for more surgical treatment at this point," according to the doctor.

Dr. Mills, a neurological surgeon, examined Claimant on May 2, 1995 and the doctor states as follows in his report (CX 8);

"Mrs. McFadden-Olds has not been seen since 1990. She comes in today indicating that several weeks ago, around Easter time, she developed severe pain involving the right low back radiating into her right lower extremity. She was evaluated thereabouts at Kaiser Health Plan and was treated with Motrin. At that time she was diagnosed as having a back sprain. Since then she has continued to experience ongoing severe pain throughout the lumbosacral region of her back which has been aggravated by walking. Her pain involves primarily the anterior and lateral thighs. Standing aggravates the latter. She has had intermittent pain involving the right lower extremity, but nothing like what she is experiencing at this particular time. She has not worked since around Easter of 1995. She denies any sphincteric dysfunction.

"ALLERGIES: Penicillin.

"EXAMINATION: She is alert and fully oriented. Range of motion of her lumbosacral spine is limited. Anterior flexion is accomplished to 40 degrees. Lateral flexion on both sides, 13 degrees, with hyperextension at 9 degrees producing pain throughout her low back region, especially on the right side. Passive straight leg raising on the left at 50 degrees is associated with low back and left lower extremity pain. Passive straight leg raising on the right at 65 degrees produces low back pain. She demonstrates no spasm throughout her lumbar region at this time. Other modalities of her examination reflect no change, **i.e.**, no focal motor deficit in the lower extremities.

"IMPRESSION: Acute severe lumbosacral sprain with associated lumbar radiculopathy.

"RECOMMENDATION: I am referring her to physical therapy of her lumbar region. A magnetic resonance image scan of the lumbosacral spine has been requested. I shall re-evaluate her in approximately three weeks or before if necessary," according to the doctor.

Claimant's medical records were reviewed at The Work Rehab Center at Inova Mount Vernon Hospital and Dr. Roger V. Gisolfi

concludes as follows in his July 31, 1997 report (CX 2):

"IMPRESSION: CHRONIC LOW BACK AND RIGHT LOWER EXTREMITY PAIN, STATUS POST LAMINECTOMY AND FUSION.

"COMMENT: In response to Question No. 1, the patient has complaints of low back and right lower extremity pain as well as a sensory disturbance of the right lower extremity. Her neuromotor examination is normal with negative straight leg raising, normal reflexes, and normal muscle testing. Her sensory deficit is non-anatomic in distribution. Her radiating pain down the leg has been attributed to L5 radiculopathy; however, the patient does not have objective clinical findings to support the L5 nerve root as a specific generator of pain.

In answer to Question No. 3, I do not concur with the proposed surgery. Unless there are clinical or EMG findings implicating the L5 nerve root, this structure should not be subjected to additional surgery on the basis of the patient's subjective complaints. It is noted that a laminectomy at this level was performed at the time of the most recent surgery on 6 December 1995. In addition, if the patient's fusion is stable, I do not see the purpose in removing the instrumentation.

"In response to Question No. 4, I believe this patient would benefit from a functionally directed Physical Therapy or Work Hardening Program. In addition, the patient did have relief of symptoms following epidural blocks in 1995 although this was short-lived. She apparently has arachnoiditis upon myelography in February 1997. Another course of epidural steroid blocks may be beneficial. In addition, the patient has been placed on Tegretol for her pain but the effect of this is unclear. A trial of Neurontin should be considered. In addition, no mention is made in the record of a sleep disturbance but the use of tricyclic antidepressant medication in the evening is an aid to sleep and can be beneficial for the management of patient's with chronic pain.

"In response to Question No. 5, I believe Ms. Webb-McFadden could benefit from Work Hardening as previously noted. I believe she should be monitored in the future for conservative management. She may need physical therapy services on an intermittent basis for exacerbations of pain. There dies not appear to be any short-term need for surgical intervention although such might be necessary in the future if further degenerative changes occur.

"The patient should be capable of working at the light to medium physical demand level. It is noted in the medical record that the patient is of small stature. She had been employed as a clerk and should be able to resume activities at this level of physical function.

"Hopefully, these observations will be of assistance in your management of Ms. Webb-McFadden," according to the doctor.

Claimant was then referred to Dr. Hampton J. Jackson, Jr., an orthopedic surgeon, and the doctor states as follows in his October 2, 1995 report (CX 1):

"CHIEF COMPLAINT: Pain in the back.

"HISTORY AND EXAMINATION: This patient comes today with complaints of continued pain in the back which have slowly worsened since 1981. She also complains of pain radiating into the right leg which has slowly worsened to the point where she could no longer work in May 1995. She subsequently saw Dr. Mills who xrayed the patient and initially operated on this patient in 1981 for a disc rupture and MRI and xrays all confirm the fact that she has developed a significant instability at L4-L5 with a Grade I spondylolisthesis. She was seen here last on 9-15-95 by my associate who referred this patient to me. Xrays reviewed on that patient show that her spondylolisthesis is not stable. She rotates off to the right side. There is actually interruption in the posterior elements seen on xrays and she is starting to calcify some in the posterior longitudinal ligaments. This level of spondylolisthesis and motion translates the normally oval foramen to a very flattened opening for the 4th nerve root. In

addition her complaints are primarily in the distribution of L5 so this also affects the more central cord equina. She denies bowel or bladder abnormalities. The hypoesthesia in the lower extremity on the right side is primarily in the distribution of L5 more so than L4. There is no involvement of the S1 root. This patient is probably at the most 100 lbs, 5'4".

"IMPRESSION: Post laminectomy spondylolisthesis L4-L5 with radiculopathy secondary to the dynamic instability associated with the spondylolisthesis.

"COMMENT: This spondylolisthesis is a direct relationship from the disc injury sustained in 1981 and the need for surgery. There is no evidence of additional or intervening injury or incident thus this is a late sequela of a lumbar disc rupture treated by laminectomy surgery. This patient is an excellent candidate both in physical size and condition for a stabilization procedure at L4-L5 and fusion. Attitude wise I think as soon as her pain symptoms subside she would return to gainful employment and I think with the proposed procedure this is very possible since we do employ bi cortical technique of pedicle screw fixation with the use of the TSRH instrumentation system."

Dr. Jackson next saw Claimant on December 21, 1995 and the

doctor states as follows in his report (CX 1):

"The patient returns today. There are still paresthesias but it is under better control with the Tegretol. She had one episode of her legs giving way but in general I think she is doing extremely well. She has an excellent amount of bone on xrays today. She has good maintenance of a Grade II spondylolisthesis. We decided not to reduce the spondylosis as she had adequate room in the foramen and we did a foraminotomy as well as facetectomy. She has excellent fixation from L3-L4 to L5-S1 and today she will be fitted with a fusion stimulator in an attempt to shorten the fusion healing time. There is only one big problem with this patient in that she is a smoker and smoking tremendously decreases the fusion rate and fusion ability. We frankly would like for her to stop smoking. I would recommend that she stop smoking and we will see how she does with this. She is to take it day by day. She certainly is not fit for any employment," according to the doctor.

Dr. Jackson next saw Claimant on January 22, 1996, at which time he reported (CX 1):

"The patient returns today. She still has some paresthesia in the right leg but she is better with the Tegretol. She has difficulty laying on her back but she is only 6 weeks and she does not use a brace as she is small and she can get away with not using a brace. This indicates that her stabilization is very good and what she is having is reactive spasm.

"At this present time her progress is satisfactory. I would recommend that she continue to diminish activities. I will not need to see her back for another 6 weeks at which time we will re-x-ray her which will be 3 months after surgery for fusion check. She has been fitted with the fusion stimulator and hopefully this will ensure our fusion as it usually does when the patient is a nonsmoker but this patient is a smoker therefore we will take all precautions here as we certainly wish this to be her final procedure. We will see her back in 6 weeks. She will be on medication," according to the doctor.

Dr. Jackson continued to see Claimant as needed between March 18, 1996 and August 26, 1996 (CX 1), at which time he reported as follows:

"The patient returns today. She is now 8 months after surgery. She is having some slowly increasing pain in the right leg in

the distribution of L5 on the right side. She does not have any pain on the left side.

“Xrays taken show she does have fusion mass and fusion bone present but it is not consolidating yet into a mass. She had a generous foraminotomy at L4-L5 and less so at L5-S1. It is hard to say whether her fusion will heal but certainly it has not yet. She had a two level fusion so 9 to 12 months is not unusual for these types of fusions. There is no loosening of any of the screws or rods and she does have a significant spondylolisthesis at L4-L5. At surgery we did a very generous foraminotomy there rather than try to reduce this as it was just between Grade I and Grade II spondylolisthesis.

“The prognosis I feel is good for this patient. I explained to the patient that sometimes these recurrent leg symptoms are due to some bony over growth of the facets and irritation of the L5 root and this would be more central than foraminal unless it is at the L5 level on the right side. On that side she has a good foraminotomy and a good laminectomy. This pattern is not that of arachnoiditis or significant scarring, it is from compression, from a bony edge or ligamentum flavum hypertrophy.

“I would recommend for this patient to be on Tegretol as this may help the leg symptoms somewhat. She will continue and try to diminish or stop her smoking and I strongly suspect this patient may end up being a two stage procedure where once her fusion heals we can remove the hardware and decompress the right L5 nerve root which should free her nerve pain. At this particular time I cannot say for sure when she will be fused. I would not recommend increasing her activities before she fuses as this will also hinder her fusion effort. Once again I asked the patient to stop smoking not only because of the cigarette smoke which decreases oxygen alone but also nicotine itself is a negative influence for fusion healing which means Nicotrol and other anti-smoking agents are also not indicated,” according to the doctor.

Dr. Jackson continued to see Claimant as needed between November 12, 1996 and March 27, 1997, at which time the doctor reported as follows (CX 1):

“The patient returns today. She has a recent myelogram and a MRI post myelogram. It appears that her roots and findings above L4-L5 and L5-S1 are within normal limits. The myelogram shows she has a Grade I spondylolisthesis at L4-L5. Her

fixation system is well intact with no loosening. There is clumping of the nerve roots down at L5. The L5 root is clumped on one side. It seems to be absent on the left side. Her L4 roots look quite satisfactory.

"The patient has post-epidural post-laminectomy scarring and this is responsible for her leg pain. Also her fusion is not healed totally yet, but she does have enough bone left that I think these will eventually heal.

"At the present time I will recommend that we simply observe this patient. She will continue to improve. It is my opinion that she appears to have improved.

"Examination shows still tenderness, spasm and restriction of motion in the back and hyperextension in the distribution of L5 on the left side more than on the right. The patient is not fit presently at this time. I will see her back in about a month for follow up examination and evaluation for the fusion.

"**ADDENDUM: The patient does a bit of irritated phenomena of her lower back and we can take care of this once her fusion heals with safe removal of the hardware. I do not think she is going to need a re-fusion or the like. I think these fragments will eventually go ahead and coalesce to a solid fusion over the next six months**," according to the doctor. (Emphasis added)

As of April 24, 1997, Dr. Jackson stated as follows (CX 1):

"The patient returns today with right-sided symptoms. She has back pain and right leg pain intermittently, but it is very severe. Sometimes she goes several days without any pain at all, but that is really when she is doing nothing with no lifting, bending or prolonged sitting.

"It has been more than year. We will not x-ray the patient today. I explained to the patient that if indeed her fusion is well taken we can always remove her device and look at the nerve root, but if there is significant epidural scarring it may not be possible to make her significantly better. Again sometimes you can never be sure until an exploration is done. She is certainly not fit for any employment presently," according to the doctor.

As of September 15, 1997, Dr. Jackson stated as follows (CX

1):

“The patient returns today. She admits the strength is not significantly improved. On examination there is still a fair amount of tenderness. Xrays taken show the fusion is taking on the right side but not significantly on the left. She has another 3 to 6 months before the left side completely takes. She is thin so we may have to remove her hardware when she is totally fused however I do not need to see her back before another 3 months,” according to the doctor.

As of November 3, 1997, Dr. Jackson stated as follows (CX 1):

“There are still significant symptoms in the right leg and buttock areas, as well as the lower back, more on the right side than the left side. There is still a fair amount of tenderness and some spasm, with restriction of motion. Straight leg raise is not impressive on the right side. She still has a lot of pinching in her back in addition to her leg pain.

“Before we rush into any additional surgical procedures, we will place her on an anti-inflammatory agent, specifically, Tegretol 1 tablet twice a day, until I see her back in two weeks. If after a week she is not having any significant improvement, she can take 1 tablet three times a day for the second week. She is not fit for any employment,” according to the doctor.

As of December 4, 1997, Dr. Jackson stated as follows (CX 1):

“The patient returns for follow-up today with back pain and right leg pain. The pain goes from the iliac crest area down to the ankle in the distribution of L5; no symptoms in the bottom of her foot. She complains of her knee locking up, so we may be dealing with some L4 symptomatology too. This is perfectly compatible with her status. She has had a traumatic spondylolisthesis and fusion, and she is showing evidence of foraminal stenosis in addition to low back pain.

“At this time, we have certainly waited long enough for her to improve, she has not been helped significantly by Tegretol. I am recommending that we explore the right side only. She will need a foraminotomy and a good look at the L4-5 and S1 nerve roots on that side. If indeed there is loosening, which might very well be the case, then we can either replace it or remove

it and I think this offers the best chance if there is ever going to be any return to gainful employment," according to the doctor.

As of December 18, 1997, Dr. Jackson stated as follows (CX 1):

"The patient returns for follow-up. She continues to complain of back pain and walks with an antalgic gait. She had a wooden cane, which was too long for her causing her to walk in a vaulted manner. This exaggerated her back pain and caused an increasingly painful gait.

"After the gait analysis, I prescribed an adjustable cane which I feel is medically necessary and gave her a prescription for Voltaren-SR 100 mg to be taken every evening with food as an anti-inflammatory medication. She is to discontinue her Motrin and perform activities to tolerance. She will be seen in two to three weeks for follow-up," according to the doctor.

Claimant was examined at the National Rehabilitation Hospital on February 3, 1998 and Dr. Babak Arvanaghi, Director, Interventional Pain Management Services, concluded as follows in his report (CX 3):

"Radiological exam: CT myelogram in 02/97 was consistent with arachnoiditis.

"Assessment: Miss Webb-McFadden appears to have chronic low back pain which is consistent with chronic lumboradicular syndrome with possible arachnoiditis and secondary hypofascial pain syndrome. She has also a concomitant psychological overlay.

"Plan:

1. Physical therapy for range of motion exercises, therapeutic exercises, manual therapy, functional mobility, home exercise program as well as gentle stretching.

2. Pain psychologists to assess psychosocial issues.

3. Elavil...

4. Neurontin...

5. Discontinue Tegretol slowly.

6. Followup in 3 weeks."

As of March 2, 1998, Dr. Jackson reported as follows (CX 1):

"The patient continues to have chronic low back pain, with radiation into the right buttocks down to the calf and the right ankle. She walks with an antalgic gait, with the aid of an adjustable crutch, which improves her gait somewhat.

"At this point, the patient was made aware of the possibility of exploratory surgery on the right L5-S1 area to both solve the lumbar stenosis and possible herniated disc on the right side. We are holding x-rays for the next visit and she is to talk to Dr. Jackson regarding the proposed surgery," according to the doctor.

As of April 27, 1998, Dr. Jackson stated as follows (CX 1):

"The patient returns today having quite a bit of symptoms on the right side. Her legs have been giving away. She has had a fair number of falls from her continued weakness. She still persists with a cane and needs it for the right lower extremity.

"This patient again may require additional surgery. We will send her first for an MRI of the lumbar spine. I will see her back in a couple of weeks for follow-up examination and evaluation. She is not fit for any gainful employment," according to the doctor.

The MRI took place on January 28, 2000 and Dr. Carl Silverio read that test as showing (CX 5):

"FINDINGS: The patient is status post laminotomy from L4 through S1. There are posterior stabilization spinal rods bilaterally from L4 through S1 with pedicle screws in place at these levels.

There is grade I spondylolisthesis at the level of L4-5. This was present on the patient's prior myelogram from an outside institution performed on 01/14/97. Since the patient's prior examination there has been mild interval increase in the grade I spondylolisthesis at this level.

The vertebral body heights are maintained.

There is narrowing of the intervertebral disk space at L4-5 as well. This also appears fairly increased since the patient's prior examination.

No significant spinal stenosis is identified. No large disk herniations are identified. The neural foramina appear patent.

The visualized retroperitoneal soft tissues are within normal limits.

There is minimal clumping of the nerve roots of the cauda equina. This was present on the prior study however and is without significant interval change.

"IMPRESSION:

1. Postoperative changes as above from L4 through S1.

2. Grade I spondylolisthesis at L4-5 which has increased since the patient's prior outside examination from 01/14/97.

3. Intervertebral disk space narrowing at L4-5 which has also increased," according to the doctor.

As of October 5, 1998, Dr. Jackson reported as follows (CX 1):

"The patient returns today. She is still having right leg pain and lower back pain. Xrays taken show instrumentation at L4-L5 and L5-S1. Surgery was four years ago. The fusions have not taken. They appear to be taken but I am guarantee they are not. There seems to be some facet over growth at L5-S1 and this is responsible for the symptoms in the L5 distribution.

"She is not fit for work. She is a surgical candidate. We will schedule her for surgery to be done in the nearest possible future. She is not fit for any gainful employment. Hopefully and especially considering her positive attitude a successful procedure in all likelihood make it possible for her to do some light work in the future," according to the doctor.

As of February 11, 1999, Dr. Jackson stated as follows (CX 1):

"The patient returns today still having right leg pain that seems to be both in the L5 and S1 distribution, which means we

may be dealing at the L4-5, L5-S1 level. She has much better symptoms on the left, but her left leg also gives away and there is plantar flexion and weakness on the right. She uses a cane for support to keep her legs from giving way. There is eversion weakness on the right, there is a minimally diminished right ankle jerk compared to the left. She has difficulty even sitting with pain in the right buttock. Her symptoms are that of foraminal stenosis related to fusion hypertrophy and overgrowth, as a consequence of her injury and need for surgery. She would benefit from additional surgery, but without guarantee. She cannot stand or even sit, lift, push, or pull enough for any gainful employment," according to the doctor.

Dr. Jackson sent the following letter to U.S.O.P.M. on March 22, 1999 (CX 1):

"Ms. McFadden continued under my care. She is not doing very well despite the fact that she has had back surgery. She has a persistent back pain as well as evidence of nerve damage in the right lower extremity.

"Current clinical findings include persistent tenderness and spasm with weakness to extension of the right knee and one grade less weakness to dorsi and plantar flexion right lower extremity and the use of a cane.

"This patient's specific medical condition is again post-laminectomy syndrome with hypertrophy and over growth of lamina and facets causing foraminal stenosis. Her prognosis is guarded.

"This patient will require additional surgery which will be done sometime in the next 3 months. Certainly there is a significant risk of injury and hazard to this patient and to other should this patient attempt to perform the position similar to the one she had before she retired," according to the doctor.

As of May 10, 1999, Dr. Jackson stated as follows (CX 1):

"The patient returns today. She is not better; we have waited and waited and waited. She is not going to get better. She is scheduled for surgery next month.

"We will refill her medication. She is certainly not fit for any gainful employment. If there is any hope of her being able to return to gainful employment and remain at gainful

employment, surgery will be necessary," according to the doctor.

Dr. Jackson sent the following letter to Claimant's attorney on September 20, 1999 (CX 1):

"Thank you for your letter to me dated September 6, 1999 regarding Debra Webb, who continues under my care. She has a chronic decompensated lower back condition that has required surgery and she presently continues with symptoms.

"I do agree that her symptoms are a combination of arachnoiditis and possible retained hardware, but strongly there is clear indication that the level above her fusions and stabilization at the L3-4 level is breaking down and is a cause of pain. I do agree that surgery will be necessary in the future and I have also explained to this patient that removal of the hardware may cause some improvement, but with no guarantee.

"However, this patient, I feel, is not fit for any gainful employment. Any significant increase in activities such as are required by her work would hasten the breakdown of the L3-4 level and significant aggravate her arachnoiditis," according to the doctor.

As of January 24, 2000, Dr. Jackson stated as follows in explaining to Claimant the significance of stenosis (CX 1):

"The patient returns today. She still has significant symptoms, increased pain in the back and legs with activity, prolonged standing or walking, with giving way of the leg in addition to pain and cramping into the leg, as well as continued signs of stenosis.

"I explained to the patient that stenosis in some circumstances is difficult to clearly distinguish by some of the tests currently employed, even the MRI or myelogram, or combined myelogram/CT scan, however the symptoms and clinical picture are classic. However it is also good to have a myelogram and CT scan to attempt to identify possible specific areas of dural encroachment, whether it be central, pre-foraminal or foraminal. I explained to her in cases in which there has been multiple surgical procedures, laminectomies or even a single laminectomy, the body attempts to stabilize this area with first increased circulation and then instability. It is very common to have thickening of the residual edges of lamina and also to facet joints especially if a fusion has been attempted and a

facetectomy not done. Sometimes the findings on MRI, myelogram or CT scan are very subtle but once again the clinical picture is unmistakable.

"I explained to the patient that I certainly agree with Dr. Sloan's recommendation to have a myelogram, but also I would add to that, more information can be obtained from a CT scan that immediately follows the myelogram so that one can take advantage of the contrast present, and also a CT scan is much more specific for bone abnormalities than an MRI or myelogram by itself, especially for nerve roots.

"I also explained to her a very important feature is that the subarachnoid space which contains the spinal fluid extends centrally out to the nerve root ganglia and thus beyond that point is quite insensitive. Often times the ganglia is in the beginning of the foramen and one is unable by these studies to detect stenosis or encroachment upon nerve root ganglia and the more distal root," according to the doctor.

As of February 14, 2000, Dr. Jackson stated (CX 1):

"The patient returns today. She still complains of back, right buttock pain and pain radiating down the right leg by dermatone, increased with activity and only partially relieved by rest. She admits to across the back pain but denies left buttock and left leg pain. The recent myelogram, CT scan and xrays taken today confirm the clinical impression of foraminal stenosis affecting primarily the L5 root. The studies confirm that the L4 pedicle on the right side has expanded with significant osteophytes coming off of it inferiorly and medially impinging upon the L5 root as it descends into L5-S1 foramen on the right side. I see no objective evidence of any loosening of her hardware and in fact she appears to be totally fused from L4-L5 to L5-S1. I do not see strong evidence of loosening of any hardware. The myelogram showed clumping but this is due to epidural scarring, not from arachnoiditis. We are not dealing with an arachnoiditis picture here.

"This is a very reliable patient. I have always felt confident that her symptoms are extremely believable. There has never been any opinion of mine that she promotes, not even in the least manner her symptoms. Considering the recent studies I do believe that she may be improved with a procedure that decompresses both the L5 and S1 roots. The hardware can be examined for loosening. Her fusions can be examined at L4-L5

and L5-S1 for stability. I see no significant evidence of any changes at the L3-L4 facets. I have indicated these findings to the patient for her to consider," according to the doctor.

As of March 27, 2000, Dr. Jackson stated as follows (CX 1):

"The patient returns today. I explained to her that in my last note I attempted to explain my interpretation of the patient's myelogram/CT scan with contrast and her plain xrays as well as symptomatology and my opinion is based on my experience of surgically treating hundreds of what we call post laminectomy/post instrumentation patients over the last twenty years. Coupled with what I know to be this patient's attitude, her body size, her powers of recovery, I do think one can reasonably expect an improved condition after carrying out the proposed surgery.

"I also explained to the patient that despite all these fancy tests, MRI's, myelogram, and CT scans, none of which present a completely accurate picture of the exact pathology that is going on with her back. These tests are only suggestive and we rely very heavily on these tests as well as our experience and the patient's symptomatology and findings, all of which point to a spinal condition that is basically that of nerve root compression, posterior and lateral, possibly due to bone overgrowth, possibly loosening of her spinal hardware, all conditions which can be surgically addressed.

"Certainly she is not fit for any gainful employment and considering this patient's attitude about work and life, her symptoms are very believable and therefore I believe very approachable," according to the doctor.

As of December 6, 2000, Dr. Jackson concluded as follows (CX 12):

"The above patient is under my care and has been so for many years. She has a progressively worsening spine condition that requires surgical intervention at this time. Without surgical intervention she will continue to suffer worsening back pain, leg pain, walking intolerance, sitting intolerance, standing intolerance, lifting disability, bending inability, and worsening sleeping ability.

"This patient's present condition is the result of progressive laminal, pedicle, and facet hypertrophy. These hypertrophied

spine elements cause significant back, buttock, and pelvic pain syndromes. These hypertrophied spine elements also cause nerve root and dural encroachment which produce pain and paresthesia syndromes in both legs.

“These hypertrophied spine elements are long term sequel complications of the disc and spine fusion surgery this patient underwent years ago which, in turn, was necessary to treat the spine injury she sustained.

“This patient’s present condition and symptoms have not just suddenly appeared. She has been slowly worsening over the last several years and will continue to worsen,” according to the doctor.

On the other hand, the Employer/Carrier (“Respondents”) have offered the February 13, 1997 report of Dr. Neil Kahanovitz (RX 1):

“**ADDENDUM:**
Deborah McFadden Webb’s myelogram and post myelogram CT scan were reviewed. There is no evidence of disc herniation or nerve root impingement. There is clear evidence of arachnoiditis distally from approximately L4 to the sacrum. However, the instrumentation does not appear to be malpositioned, nor is there evidence of impingement on the nerve roots or dural sac from structural abnormalities or instrumentation placement.

“The patient is clearly not a candidate for any additional surgical procedures and it would be recommended that surgical management continue, as additional surgery clearly would not be in this patient’s best interest,” according to the doctor.

As of March 6, 1997, Dr. Kahanovitz reports as follows (RX 1):

“Over the long term, Ms. Webb will need to be managed conservatively for her chronic pain. This may necessitate periodic visits to a physiatrist and/or internist and possibly to an orthopaedic surgeon or neurosurgeon. The frequency of these visits is difficult to project, but based on her current complaints will probably be in the range of every four to eight weeks. As stated previously, the patient is not a surgical candidate and there is no reason to think that additional surgical intervention would be necessary over the short term.

However, if further degenerative changes occur above the area of her fusion, it is possible that in the future additional surgery might be indicated. As stated, however, this is not the case in the near future. I do not feel that continued formal physical therapy will be of significant benefit over the long term, although intermittent sessions of therapy for exacerbations of her symptoms may be needed to maintain her optimal functional level. The therapy should not include passive modalities and should not be considered a long term option," according to the doctor.

As of December 29, 1997, the doctor reported as follows (RX 1):

"Debra McFadden-Webb notes that she is basically unchanged since last being seen. The patient, however, notes that her right sided radicular pain may have increased somewhat.

"On physical examination today, the patient has diffuse pain to palpation throughout the right sided paraspinal muscles as far laterally as the inferior iliac spine between approximately L3 and the sacrum. There is no significant pain to palpation in the midline or left sided paraspinal region. Extension to only five degrees and forward flexion to approximately ten degrees elicit pain in the same area as well as into the right buttock. Manual motor testing of the lower extremities is normal. The patient has negative straight leg raising, bowstring and lasegue except for referred back pain at 75 degrees on the right.

"No studies were available for review today.

"The patient does not appear to be significantly changed from her prior examination in November 1996. In the absence of any neurologic compression seen on her prior studies, there is no reason to think that the patient would be considered a good candidate for additional surgery, particularly in view of the fact that there was evidence of arachnoiditis on her previous study. There is no clinical evidence of irritation from the instrumentation even taking into account how thin the patient is, since on physical examination, the patient has diffuse pain which is not isolated to the area of the pedicle screw instrumentation.

"I would recommend that the patient continue to pursue a conservative course, which should include treatment of her arachnoidits with appropriate medication. Ideally, this would

be managed by a neurologist experienced in the treatment of arachnoiditis. The patient should continue with her exercises and should attempt to remain as active as possible; however, as stated previously, she should not be considered an ideal surgical candidate in the absence of any specific nerve root irritation or evidence of loss of pedicle screw fixation, and I would not recommend that she undergo any further surgery," according to the doctor.

Dr. Jackson issued the following report on November 27, 2000 (CX 13):

"Thank you for your note to me of 6-15-00 which has just come to my attention since you faxed a note to me on 11-17-00.

"Ms. McFadden remains under my care. I have reviewed Dr. Sloan's note. He is a bit confused on the surgeries. This patient underwent a procedure in 1995 and 1996. She underwent a posterior procedure, decompression and stabilization and she had a subsequent anterior inter body fusion which she did extremely well with. The patient has not had a consistent painful course as a result of her two surgeries performed by myself. She did quite well in fact. It has only been recently that she has started to get recurrent significant leg pain.

"My experience dictates that in such a case, when a 360 procedure is done both an anterior and posterior fusion and the patient returns with significant leg pain, then the culprit is overgrowth of the facet and lamina which is not readily diagnosed with myelograms and CT scans. This is a diagnosis made on experience in doing this particular operation over the last 24 years.

"In summary, this patient's condition has worsened. This is a consequence of her initial injury of 5-22-80 and subsequent need for surgeries. She had a good result from surgeries done by me in the last several years up until recently and then she started to get different symptoms which required different treatment.

"The symptoms that she has can be treated surgically in my experience and this opinion and decision for surgery is based on patient's symptoms and findings on examination and not totally on results of a myelogram and CT scan," according to the doctor.

Respondents have also referred Claimant for an evaluation

by Dr. Todd R. Sloan, an orthopedic surgeon, and the doctor, after the usual social and employment history, his review of the diagnostic tests and the physical examination, concludes as follows in his October 28, 1999 report (RX 2):

"**HISTORY OF PRESENT ILLNESS:** Ms. McFadden is in today for evaluation on her back and right leg. On May 22, 1980, she injured her back in a slip and fall injury that occurred at work. She initially was treated by physicians at Kaiser Permanente and later came under the care of Dr. Earl Mills who in April, 1981, performed a diskectomy at L4-L5. She was evaluated 14 months later by Dr. Spiridon Koulouis. She was seen for persisting symptoms. Dr. Koulouis, a neurosurgeon, felt that the patient had normal reflexes and no motor or sensory changes in her lower extremities. She had a negative straight leg raising examination. The patient was able to return to work in 1982 and remained employed through 1995. She was able to function as a mail courier during that period of time.

"In 1995, the patient had recurrence of her lower back pain with right lower extremity pain as well. She saw Dr. Mills again and underwent a series of epidural blocks without significant improvement in her symptoms. An x-ray and an MRI were obtained and were read as showing degenerative changes at L4-L5 with a grade I spondylosis of L4 on L5. Orthopedic consultation was obtained at this time and Dr. Hampton Jackson felt that the patient's pain was due to instability at the L4-L5 level. In December, 1995, the patient underwent a combined surgical procedure done by Dr. Mills and Dr. Jackson, consisting of laminectomies at L4, L5 and S1 in association with lateral fusion and spinal instrumentation from L4 to the sacrum. The patient did not have any improvement in her back or leg symptoms since that time. Dr. Jackson feels that although the x-rays seem to show fairly good fusion mass, her fusion has not taken. He also feels that the patient has facet hypertrophy with foraminal stenosis and has recommended foraminotomies be performed. Also, he would like to consider removal of the patient's hardware.

"The most recent test that the patient has had that I can see is a CAT scan–enhanced myelogram done in February, 1997. It was felt by that study that the patient had arachnoiditis. No other significant abnormalities were noted.

"Ms. McFadden states that she has continued to have pain and discomfort in her back that is quite disabling. She has been unable to ambulate any distance. Frequently, she has to walk with the assistance of a cane. She states that she will get her pain while walking or standing. She denies any numbness or weakness. She has had no paresthesias. She states that her pain is a tightness or squeezing type of discomfort that she then notices in the back and right buttock area as well as down into her right leg. The sensation of squeezing is intense enough that it is a significantly unsettling discomfort. Due to the persistence of her pain, she is referred for an independent medical evaluation.

"**PAST MEDICAL HISTORY:** Past medical history reveals that she otherwise enjoys fair health. Her medicines at time of presentation include Medrol Dosepak on an occasional basis, Ambien, Relafen, and Tegretol. She has a stated medical allergy to penicillin.

"**REVIEW OF SYSTEMS:** Review of systems reveals that systemically she has had no fevers, chills or weight loss. Head, ears, eyes, nose and throat have been normal...

"**SOCIAL HISTORY:** Social history reveals that she is a smoker, having about five cigarettes a day. She is a minimal ingester of alcohol...

"**X-RAYS:** On review of her x-rays which she has brought with her, she has instrumentation that appear to be pedicle screws that extend from L4 down through S1. The instrumentation appears to be in satisfactory position and alignment and has not cut out.

"In response to the questions that are posed regarding the patient's condition, I feel the following pertains:

1. I feel the patient's current diagnosis is most likely failed back syndrome, status post L4-L5 laminectomy and diskectomy and subsequent fusion with instrumentation. Secondary diagnosis, I believe is a lumbar arachnoiditis, status post her surgical procedure. On her x-rays, I see no significant evidence of degenerative disk disease at this time. Given the fact that she has had two prior surgeries and has not been at work since 1995, I think her prognosis is guarded at best.

2. I do feel that the patient's current condition is related to her injury that occurred in May, 1980. I base this on the fact that I think she does have some degree of arachnoiditis and a failed back type of picture. The arachnoiditis certainly is attributable to the surgery that occurred subsequent to her injury.

4. Skipping to #4, I feel at this time that a firm diagnosis has not been established on this patient. I do think that a repeat myelogram should be performed and carefully evaluate her nerve roots to see whether or not there is any evidence of a foraminal stenosis or facet overgrowth. Also, I think a careful evaluation of her possible arachnoiditis should be performed. If she has significant foraminal stenosis or facet overgrowth, then I think that patient may need to eventually consider surgery. If there is no significant foraminal stenosis, then I think she is not a candidate for surgery, since surgery for arachnoiditis is usually not successful as rescarring just occurs to take the place of the scar tissue that is excised. If she doe not have significant facet overgrowth and foraminal stenosis, then I think a work hardening program may benefit her. It is noted in her records that she has had a pain management evaluation and basically was a very poor complier with this program, not participating in it well at all. I think to repeat a pain management clinic, unless she absolutely agreed to participate in it thoroughly, would be a waste of time and money.

3. Lastly, coming back to question #3, I do not fee that this time that the patient is a candidate for surgery right now. I think a repeat myelogram should be done to better study her back and get another assessment of her condition. Certainly, an exploratory back condition is not indicated at this point," according to the doctor.

Dr. Kahanovitz sent the following letter to the Claimant on April 27, 2000 (RX 1 at 5):

"The myelogram report from 1/28/00 was reviewed, and there does not appear to be any significant change. This is consistent with the prior diagnosis of arachnoiditis, and my recommendations are unchanged since my previous report of December 1997."

Dr. Kahanovitz sent the following letter to Respondents'

counsel on January 11, 2001 (RX 4):

“I had the opportunity to review the medical records sent to me regarding Debra Webb-McFadden and Hampton Jackson. It appears that re-operation in the absence of significant neurologic compression on the Myelogram CT Scan and based only upon clinical impression is not reasonable and would not at this time be indicated in my opinion as well as within the accepted standard of care. Surgery without documented objective evidence of abnormality is clearly not indicated.”

On the basis of the totality of this record and having observed the demeanor and heard the testimony of a most credible Claimant, I make the following:

Findings of Fact and Conclusions of Law

This Administrative Law Judge, in arriving at a decision in this matter, is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and he is not bound to accept the opinion or theory of any particular medical examiner. **Banks v. Chicago Grain Trimmers Association, Inc.**, 390 U.S. 459 (1968), **reh. denied**, 391 U.S. 929 (1969); **Todd Shipyards v. Donovan**, 300 F.2d 741 (5th Cir. 1962); **Scott v. Tug Mate, Incorporated**, 22 BRBS 164, 165, 167 (1989); **Hite v. Dresser Guiberson Pumping**, 22 BRBS 87, 91 (1989); **Anderson v. Todd Shipyard Corp.**, 22 BRBS 20, 22 (1989); **Hughes v. Bethlehem Steel Corp.**, 17 BRBS 153 (1985); **Seaman v. Jacksonville Shipyard, Inc.**, 14 BRBS 148.9 (1981); **Brandt v. Avondale Shipyards, Inc.**, 8 BRBS 698 (1978); **Sargent v. Matson Terminal, Inc.**, 8 BRBS 564 (1978).

The Act provides a presumption that a claim comes within its provisions. **See** 33 U.S.C. §920(a). This Section 20 presumption "applies as much to the nexus between an employee's malady and his employment activities as it does to any other aspect of a claim." **Swinton v. J. Frank Kelly, Inc.**, 554 F.2d 1075 (D.C. Cir. 1976), **cert. denied**, 429 U.S. 820 (1976). Claimant's uncontradicted credible testimony alone may constitute sufficient proof of physical injury. **Golden v. Eller & Co.**, 8 BRBS 846 (1978), **aff'd**, 620 F.2d 71 (5th Cir. 1980); **Hampton v. Bethlehem Steel Corp.**, 24 BRBS 141 (1990); **Anderson v. Todd Shipyards**, **supra**, at 21; **Miranda v. Excavation Construction, Inc.**, 13 BRBS 882 (1981).

However, this statutory presumption does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a "**prima facie**" case. The Supreme Court has held that "[a] **prima facie** 'claim for compensation,' to which the statutory presumption refers, must at least allege an injury that arose in the course of employment as well as out of employment." **United States Indus./Fed. Sheet Metal, Inc., v. Director, Office of Workers' Compensation Programs, U.S. Dep't of Labor**, 455 U.S. 608, 615 102 S. Ct. 1318, 14 BRBS 631, 633 (CRT) (1982), **rev'g Riley v. U.S. Indus./Fed. Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). Moreover, "the mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." **U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, Office of Workers' Compensation Programs, U.S. Department of Labor**, 455 U.S. 608, 102 S.Ct. 1318 (1982), **rev'g Riley v. U.S. Industries/Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). The presumption, though, is applicable once claimant establishes that he has sustained an injury, **i.e.**, harm to his body. **Preziosi v. Controlled Industries**, 22 BRBS 468, 470 (1989); **Brown v. Pacific Dry Dock Industries**, 22 BRBS 284, 285 (1989); **Trask v. Lockheed Shipbuilding and Construction Company**, 17 BRBS 56, 59 (1985); **Kelaita v. Triple A. Machine Shop**, 13 BRBS 326 (1981).

To establish a **prima facie** claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that (1) the claimant sustained physical harm or pain and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. **Kelaita**, **supra**; **Kier v. Bethlehem Steel Corp.**, 16 BRBS 128 (1984). Once this **prima facie** case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. **Kier**, **supra**; **Parsons Corp. of California v. Director, OWCP**, 619 F.2d 38 (9th Cir. 1980); **Butler v. District Parking Management Co.**, 363 F.2d 682 (D.C. Cir. 1966); **Ranks v. Bath Iron Works Corp.**, 22 BRBS 301, 305 (1989). Once claimant establishes a physical harm and working conditions which could

have caused or aggravated the harm or pain the burden shifts to the employer to establish that claimant's condition was not caused or aggravated by his employment. **Brown v. Pacific Dry Dock**, 22 BRBS 284 (1989); **Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986). If the presumption is rebutted, it no longer controls and the record as a whole must be evaluated to determine the issue of causation. **Del Vecchio v. Bowers**, 296 U.S. 280 (1935); **Volpe v. Northeast Marine Terminals**, 671 F.2d 697 (2d Cir. 1981). In such cases, I must weigh all of the evidence relevant to the causation issue. **Sprague v. Director, OWCP**, 688 F.2d 862 (1st Cir. 1982); **MacDonald v. Trailer Marine Transport Corp.**, 18 BRBS 259 (1986).

The U.S. Court of Appeals for the First Circuit has considered the Employer's burden of proof in rebutting a **prima facie** claim under Section 20(a) and that Court has issued a most significant decision in **Bath Iron Works Corp. v. Director, OWCP (Shorette)**, 109 F.3d 53, 31 BRBS 19(CRT)(1st Cir. 1997).

In **Shorette**, the United States Court of Appeals for the First Circuit held that an employer need not rule out any possible causal relationship between a claimant's employment and his condition in order to establish rebuttal of the Section 20(a) presumption. The court held that employer need only produce substantial evidence that the condition was not caused or aggravated by the employment. **Id.**, 109 F.3d at 56,31 BRBS at 21 (CRT); **see also Bath Iron Works Corp. v. Director, OWCP [Hartford]**, 137 F.3d 673, 32 BRBS 45 (CRT)(1st Cir. 1998). The court held that requiring an employer to rule out any possible connection between the injury and the employment goes beyond the statutory language presuming the compensability of the claim "in the absence of substantial evidence to the contrary." 33 U.S.C. §920(a). **See Shorette,** 109 F.3d at 56, 31 BRBS at 21 (CRT). The "ruling out" standard was recently addressed and rejected by the Court of Appeals for the Fifth and Seventh Circuits as well. **Conoco, Inc. v. Director, OWCP [Prewitt]**, 194 F.3d 684, 33 BRBS 187(CRT)(5th Cir. 1999); **American Grain Trimmers, Inc. v. OWCP**, 181 F.3d 810, 33 BRBS 71(CRT)(7th Cir. 1999); **see also O'Kelley v. Dep't of the Army/NAF**, 34 BRBS 39 (2000); **but see Brown v. Jacksonville Shipyards, Inc.**, 893 F.2d 294, 23 BRBS 22 (CRT)(11th Cir. 1990) (affirming the finding that the Section 20(a) presumption was not rebutted because no physician expressed an opinion "ruling out the possibility" of a causal relationship between the injury and the work).

To establish a **prima facie** case for invocation of the Section 20(a) presumption, claimant must prove that (1) he suffered a harm, and (2) an accident occurred or working conditions existed which could have caused the harm. **See**, **e.g.**, **Noble Drilling Company v. Drake**, 795 F.2d 478, 19 BRBS 6 (CRT) (5th Cir. 1986); **James v. Pate Stevedoring Co.**, 22 BRBS 271 (1989). If claimant's employment aggravates a non-work-related, underlying disease so as to produce incapacitating symptoms, the resulting disability is compensable. **See Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986); **Gardner v. Bath Iron Works Corp.**, 11 BRBS 556 (1979), **aff'd sub nom. Gardner v. Director, OWCP**, 640 F.2d 1385, 13 BRBS 101 (1st Cir. 1981). If employer presents substantial evidence sufficient to sever the connection between claimant's harm and his employment, the presumption no longer controls, and the issue of causation must be resolved on the whole body of proof. **See**, **e.g.**, **Leone v. Sealand Terminal Corp.**, 19 BRBS 100 (1986).

Respondents contend that Claimant did not establish a **prima facie** case of causation and, in the alternative, that there is substantial evidence of record to rebut the Section 20(a), 33 U.S.C. §920(a), presumption. I reject both contentions. The Board has held that credible complaints of subjective symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case for Section 20(a) invocation. **See Sylvester v. Bethlehem Steel Corp.**, 14 BRBS 234, 236 (1981), **aff'd**, 681 F.2d 359, 14 BRBS 984 (5th Cir. 1982). Moreover, I may properly rely on Claimant's statements to establish that she experienced a work-related harm, and as it is undisputed that a work accident occurred which could have caused the harm, the Section 20(a) presumption is invoked in this case. **See**, **e.g.**, **Sinclair v. United Food and Commercial Workers**, 23 BRBS 148, 151 (1989). Moreover, Employer's general contention that the clear weight of the record evidence establishes rebuttal of the pre-presumption is not sufficient to rebut the presumption. **See generally Miffleton v. Briggs Ice Cream Co.**, 12 BRBS 445 (1980).

The presumption of causation can be rebutted only by “substantial evidence to the contrary” offered by the employer. 33 U.S.C. § 920. What this requirement means is that the employer must offer evidence which negates the connection between the alleged event and the alleged harm. In **Caudill v. Sea Tac Alaska Shipbuilding**, 25 BRBS 92 (1991), the carrier

offered a medical expert who testified that an employment injury did not "play a significant role" in contributing to the back trouble at issue in this case. The Board held such evidence insufficient as a matter of law to rebut the presumption because the testimony did not completely rule out the role of the employment injury in contributing to the back injury. **See also Cairns v. Matson Terminals, Inc.**, 21 BRBS 299 (1988) (medical expert opinion which did entirely attribute the employee's condition to non-work-related factors was nonetheless insufficient to rebut the presumption where the expert equivocated somewhat on causation elsewhere in his testimony). Where the employer/carrier can offer testimony which completely severs the causal link, the presumption is rebutted. **See Phillips v. Newport News Shipbuilding & Dry Dock Co.**, 22 BRBS 94 (1988) (medical testimony that claimant's pulmonary problems are consistent with cigarette smoking rather than asbestos exposure sufficient to rebut the presumption).

For the most part only medical testimony can rebut the Section 20(a) presumption. **But see Brown v. Pacific Dry Dock**, 22 BRBS 284 (1989) (holding that asbestosis causation was not established where the employer demonstrated that 99% of its asbestos was removed prior to the claimant's employment while the remaining 1% was in an area far removed from the claimant and removed shortly after his employment began). Factual issues come in to play only in the employee's establishment of the **prima facie** elements of harm/possible causation and in the later factual determination once the Section 20(a) presumption passes out of the case.

Once rebutted, the presumption itself passes completely out of the case and the issue of causation is determined by examining the record "as a whole". **Holmes v. Universal Maritime Services Corp.**, 29 BRBS 18 (1995). Prior to 1994, the "true doubt" rule governed the resolution of all evidentiary disputes under the Act; where the evidence was in equipoise, all factual determinations were resolved in favor of the injured employee. **Young & Co. v. Shea**, 397 F.2d 185, 188 (5th Cir. 1968), **cert. denied,** 395 U.S. 920, 89 S. Ct. 1771 (1969). The Supreme Court held in 1994 that the "true doubt" rule violated the Administrative Procedure Act, the general statute governing all administrative bodies. **Director, OWCP v. Greenwich Collieries**, 512 U.S. 267, 114 S. Ct. 2251, 28 BRBS 43 (CRT) (1994). Accordingly, after **Greenwich Collieries** the employee bears the burden of proving causation by a preponderance of the

evidence after the presumption is rebutted.

As the Respondents dispute that the Section 20(a) presumption is invoked as to the reasonableness of the surgery, **see Kelaita v. Triple A Machine Shop**, 13 BRBS 326 (1981), the burden shifts to employer to rebut the presumption with substantial evidence which establishes that claimant's employment did not cause, contribute to, or aggravate his condition. **See Peterson v. General Dynamics Corp**., 25 BRBS 71 (1991), **aff'd sub nom. Insurance Company of North America v. U.S. Dept. of Labor**, 969 F.2d 1400, 26 BRBS 14 (CRT)(2d Cir. 1992), **cert. denied,** 507 U.S. 909, 113 S. Ct. 1264 (1993); **Obert v. John T. Clark and Son of Maryland,** 23 BRBS 157 (1990); **Sam v. Loffland Brothers Co**., 19 BRBS 228 (1987). The probative testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. **See Kier v. Bethlehem Steel Corp**., 16 BRBS 128 (1984). If an employer submits substantial countervailing evidence to sever the connection between the injury and the employment, the Section 20(a) presumption no longer controls and the issue of causation must be resolved on the whole body of proof. **Stevens v. Tacoma Boatbuilding Co.**, 23 BRBS 191 (1990). This Administrative Law Judge, in weighing and evaluating all of the record evidence, may place greater weight on the opinions of the employee's treating physician as opposed to the opinion of an examining or consulting physician. In this regard, **see Pietrunti v. Director, OWCP**, 119 F.3d 1035, 31 BRBS 84 (CRT)(2d Cir. 1997). **See also Sir Gean Amos v. Director, OWCP**, 153 F.3d 1051 (9th Cir. 1998), **amended**, 164 F.3d 480, 32 BRBS 144 (CRT)(9th Cir. 1999).

In the case **sub judice**, Claimant alleges that the harm to her bodily frame, **i.e.**, her chronic lumbar disc syndrome, resulted as the natural and unavoidable consequences of her May 22, 1980 injuring while working for the Employer. As the Respondents have introduced no evidence severing the connection between such harm and Claimant's maritime employment, Claimant has established a **prima facie** claim that such harm is a work-related injury, as shall now be discussed.

As noted above, the sole issue is whether the surgery recommended by Dr. Jackson is reasonable and necessary, and issue I shall now resolve.

Medical Expenses

An Employer found liable for the payment of compensation is, pursuant to Section 7(a) of the Act, responsible for those medical expenses reasonably and necessarily incurred as a result of a work-related injury. **Perez v. Sea-Land Services, Inc.**, 8 BRBS 130 (1978). The test is whether or not the treatment is recognized as appropriate by the medical profession for the care and treatment of the injury. **Colburn v. General Dynamics Corp.**, 21 BRBS 219, 22 (1988); **Barbour v. Woodward & Lothrop, Inc.**, 16 BRBS 300 (1984). Entitlement to medical services is never time-barred where a disability is related to a compensable injury. **Addison v. Ryan-Walsh Stevedoring Company**, 22 BRBS 32, 36 (1989); **Mayfield v. Atlantic & Gulf Stevedores**, 16 BRBS 228 (1984); **Dean v. Marine Terminals Corp.**, 7 BRBS 234 (1977). Furthermore, an employee's right to select his own physician, pursuant to Section 7(b), is well settled. **Bulone v. Universal Terminal and Stevedore Corp.**, 8 BRBS 515 (1978). Claimant is also entitled to reimbursement for reasonable travel expenses in seeking medical care and treatment for his work-related injury. **Tough v. General Dynamics Corporation**, 22 BRBS 356 (1989); **Gilliam v. The Western Union Telegraph Co.**, 8 BRBS 278 (1978).

In **Shahady v. Atlas Tile & Marble**, 13 BRBS 1007 (1981), **rev'd on other grounds**, 682 F.2d 968 (D.C. Cir. 1982), **cert. denied**, 459 U.S. 1146, 103 S.Ct. 786 (1983), the Benefits Review Board held that a claimant's entitlement to an initial free choice of a physician under Section 7(b) does not negate the requirement under Section 7(d) that claimant obtain employer's authorization prior to obtaining medical services. **Banks v. Bath Iron Works Corp.**, 22 BRBS 301, 307, 308 (1989); **Jackson v. Ingalls Shipbuilding Division, Litton Systems, Inc.**, 15 BRBS 299 (1983); **Beynum v. Washington Metropolitan Area Transit Authority**, 14 BRBS 956 (1982). However, where a claimant has been refused treatment by the employer, he need only establish that the treatment he subsequently procures on his own initiative was necessary in order to be entitled to such treatment at the employer's expense. **Atlantic & Gulf Stevedores, Inc. v. Neuman**, 440 F.2d 908 (5th Cir. 1971); **Matthews v. Jeffboat, Inc.**, 18 BRBS at 189 (1986).

An employer's physician's determination that Claimant is fully recovered is tantamount to a refusal to provide treatment. **Slattery Associates, Inc. v. Lloyd**, 725 F.2d 780 (D.C. Cir.

1984); **Walker v. AAF Exchange Service**, 5 BRBS 500 (1977). All necessary medical expenses subsequent to employer's refusal to authorize needed care, including surgical costs and the physician's fee, are recoverable. **Roger's Terminal and Shipping Corporation v. Director, OWCP**, 784 F.2d 687 (5th Cir. 1986); **Anderson v. Todd Shipyards Corp.**, 22 BRBS 20 (1989); **Ballesteros v. Willamette Western Corp.**, 20 BRBS 184 (1988).

Section 7(d) requires that an attending physician file the appropriate report within ten days of the examination. Unless such failure is excused by the fact-finder for good cause shown in accordance with Section 7(d), claimant may not recover medical costs incurred. **Betz v. Arthur Snowden Company**, 14 BRBS 805 (1981). **See also** 20 C.F.R. §702.422. However, the employer must demonstrate actual prejudice by late delivery of the physician's report. **Roger's Terminal**, **supra**.

It is well-settled that the Act does not require that an injury be disabling for a claimant to be entitled to medical expenses; it only requires that the injury be work related. **Romeike v. Kaiser Shipyards**, 22 BRBS 57 (1989); **Winston v. Ingalls Shipbuilding**, 16 BRBS 168 (1984); **Jackson v. Ingalls Shipbuilding**, 15 BRBS 299 (1983).

On the basis of the totality of the record, I find and conclude that Claimant has shown good cause, pursuant to Section 7(d). Claimant advised the Employer of her work-related injury on the same day and requested appropriate medical care and treatment. However, while the Respondents did accept the claim and did authorize certain medical care, they have consistently failed to approve the surgery recommended by Dr. Jackson. Thus, any failure by Claimant to file timely the physician's report is excused for good cause as a futile act and in the interests of justice as the Employer refused to accept the claim.

Initially, I note that Claimant testified most credibly before me and it was obvious to this Administrative Law Judge that she was experiencing severe and intense pain, that she badly needs that surgical procedure and that she wants to undergo the procedure in an attempt to relieve her chronic pain.

Claimant’s initial injury occurred on May 22, 1980. Claimant underwent surgery on April 29, 1981 and inter body fusion in December of 1995. Despite these procedures, Claimant developed progressive worsening. Claimant’s injury causes her

legs to be numb, weak and give out. She cannot walk without the use of a cane or using an electronic wheelchair. She can only wash dishes and cook while sitting on a stool. The pain has become worse. Dr. Jackson believes the problem to be overgrowth of the facet and lamina which he opines is not readily diagnosed with myelograms and CT scans. Dr. Jackson recognizes these symptoms and this source from 24 years of experience and has been treating Claimant for over five years. Additionally, Claimant has testified that she can feel everything, the pins sticking in her back, and agrees with Dr. Jackson that the procedure to remove the devices from her back would be beneficial and worth the risk.

A treating physician's opinion is entitled to special weight. "We afford greater weight to a treating physician's opinion because 'he is employed to cure and has a greater opportunity to know and observe the patient as an individual.'" **Amos v. Director, OWCP**, 153 F.3d 1051 (9th Cir. 1998)(quoting **Magallanes v. Bowen**, 881 F.2d 747, 751 (9th Cir. 1989)(quoting **Sprague v. Bowen**, 812 F.2d 1226, 1230 (9th Cir. 1987)). In the **Amos** case, the conflicting opinions of two other surgeons retained by the employer to examine the claimant acknowledged that surgery might help the claimant, but both rejected the idea. Although both favored a conservative course, neither surgeon could say that the surgery option advocated by the treating physician would be totally unreasonable.

The facts of the present case are similar to those in **Amos**. Both surgeons retained by the Employers have opined that surgery would be inappropriate at this time. (RX 1, RX 2) Dr. Jackson, Claimant's treating surgeon for over five years, is of the opinion that surgery at this time is necessary to alleviate her ailments. However, in the **Amos** case the physicians were not expressly able to say in their reports that surgery would be an unreasonable option, whereas here, both surgeons have explicitly stated that surgery would not only be unreasonable, but inappropriate. In the Fourth Circuit, courts have been reluctant to overcome this type of conflicting testimony *solely* on the presumption that the treating surgeon's opinion should be entitled to special weight. "[N]either this circuit [Fourth Circuit] nor the Benefits Review Board has ever fashioned either a requirement or a presumption that treating or examining physicians' opinions be given greater weight than opinions of other expert physicians." **Sterling Smokeless Coal Co. v. Akers; Director, OWCP**, 131 F.3d 438, 441 (4th Cir. 1997)(quoting **Grizzle**

v. Pickands Mather and Co., 994 F.2d 1093, 1097 (4th Cir. 1993)). Nevertheless, the Fourth Circuit does recognize that a treating surgeon who has had more contact with the claimant over a long period of time is an important factor in determining credibility.

Here, the issue is the interpretation of Claimant's Myelogram CT Scan of January 28, 2000. Both the Respondents' physicians and Dr. Jackson have access to the Myelogram CT Scan. Dr. Jackson believes that the Myelogram CT Scan does not tell the full story, and that the cause of the problem as determined by all the factors including the clinical examination, can be linked to overgrowth of the facet and lamina. The removal of the hardware placed in the Claimant's back during the fusion operation in December 1995 is the most likely culprit of the Claimant's medical problems. The conflicting opinions offered by Drs. Kahanovitz and Sloan are based on the Myelogram CT Scan, and one visit to Dr. Sloan and two visits to Dr. Kahanovitz by the Claimant. Neither Dr. Kahanovitz nor Dr. Sloan totally rejects the idea that the devices in Claimant's back might be the cause of her ailments. In fact, they never address it in their reports. Moreover, neither rules out the possibility of surgery, and both recognize that it may be necessary after "another assessment of her condition" or if "further degenerative changes occur." Dr. Jackson's diagnosis is based on a much more involved history with the Claimant. There is no evidence in the record that any of these three physicians has special expertise, credentials or qualifications to give considerable weight on his opinion on that basis. However, Dr. Jackson has indicated and it is in evidence that he has performed many of these surgeries.

Therefore, a recommendation given by Claimant's treating physician should be given more weight than that of a physician not familiar with Claimant's medical history, especially when the conflicting reports do not necessarily definitively rule out the treating physician's interpretation of proper treatment and possibility of surgery as an ultimate solution to Claimant's symptoms, and I so find and conclude.

Accordingly, I find and conclude that the surgery recommended by Dr. Jackson is reasonable and necessary and that Claimant is entitled to an award of that surgical procedure.

In so concluding, I have given greater weight to the well-

reasoned and well-documented opinions of Dr. Mills and Dr. Jackson, Claimant's treating physicians since at least April 28, 1981. (CX 6)

Dr. Mills performed the first surgery on the Claimant, has treated her for many years and Dr. Jackson has been treating Claimant since October 2, 1995. (CX 1) Dr. Jackson performed fusion surgery and it is that surgery - involving the placement of certain hardware in Claimant's lumbar spine - that has brought about the need for this additional surgery, **i.e.**, the removal of such hardware, as apparently some tissue or nerves have become wrapped around the hardware.

As noted Claimant desperately needs the surgery, wants to undergo the surgery and she credibly testified that this will be the last back surgery that she undergoes, Claimant stoically remarking that she hopes the surgery is successful; if not, then she does not wish any further surgery, and she will just have to learn to live with the chronic lumbar disc syndrome, daily taking her regimen of pain syndrome. The surgery should also be performed because successful surgery and her young age will allow her many years of lesser pain symptoms. She should be given that opportunity, in my judgment.

This case is the classic battle of the medical experts and, pursuant to **Amos, supra**, and **Pietrunti, supra**, I have given greater weight to the opinions of Dr. Jackson and Dr. Mills. While I am impressed with the professional qualifications of Dr. Kahanovitz and Dr. Sloan, I simply cannot accept their opinions herein, given the intense and severe pain daily experienced by the Claimant, given Claimant's willingness to undergo that surgery and given the findings consistently seen on Claimant's diagnostic tests since her 1995 fusion surgery, especially her January 28, 2000 MRI.

This case is "on all fours" with the factual scenario presented the U.S. Court of Appeals for the Ninth Circuit in **Amos, supra**, I agree with that Court when it states as follows at 153 F.3d 1054 (Emphasis added):

> **Where an injured employee seeks benefits under the (Act), a treating physician's opinion is entitled to special weight. As we have explained in the context of Social Security cases, "(w)e afford greater weight to a treating physician's opinion because 'he is**

> **employed to cure and has a greater opportunity to know and observe the patient as an individual.'"** (Citations omitted)

The Court, in discussing Section 7 of the Act, concludes as follows (**Id.**):

> **Although the Employer is not required to pay for unreasonable and inappropriate treatment, when the patient is faced with two or more valid medical alternatives, it is the patient, in consultation with his own doctor, who has the right to chart his own destiny."** (Citation omitted)(Emphasis added)

As I find and conclude that the surgical procedure recommended by Dr. Jackson is reasonable and necessary, Claimant is hereby awarded that procedure and Respondents shall immediately authorize and pay for that surgical procedure, as well as all other expenses incidental thereto.

Attorney's Fee

Claimant's attorney, having successfully prosecuted this claim, is entitled to a fee to be assessed against the Employer and its Carrier (Respondents). Claimant's attorney has not submitted his fee application. Within thirty (30) days of the receipt of this Decision and Order, he shall submit a fully supported and fully itemized fee application, sending a copy thereof to the Respondents' counsel who shall then have fourteen (14) days to comment thereon. A certificate of service shall be affixed to the fee petition and the postmark shall determine the timeliness of any filing. This Court will consider only those legal services rendered and costs incurred after the date of the informal conference. Services performed prior to that date should be submitted to the District Director for his consideration.

ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I issue the following.

It is therefore **ORDERED** that:

1. The Respondents shall continue to furnish such reasonable, appropriate and necessary medical care and treatment as the Claimant's work-related injury referenced herein may require, including authorization of and payment for the surgical procedure recommended by Dr. Jackson, subject to the provisions of Section 7 of the Act.

2. Claimant's attorney shall file, within thirty (30) days of receipt of this Decision and Order, a fully supported and fully itemized fee petition, sending a copy thereof to Respondents' counsel who shall then have fourteen (14) days to comment thereon. This Court has jurisdiction over those services rendered and costs incurred after the informal conference.

DAVID W. DI NARDI
Administrative Law Judge

Dated:

Boston, Massachusetts
DWD:jl